Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM N WISHARD MEMORIAL HOSPITAL	**1001 W 10TH ST INDIANAPOLIS, IN 46202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for a State hospital complaint investigation. Complaint: #IN00114964 -Unsubstantiated; lack of sufficient evidence. #IN00113178- Unsubstantiated; lack of sufficient evidence. Survey Date: 02/4/13 Facility #: 005023 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 02/11/13	S 000		